



**STATE OF TENNESSEE
DEPARTMENT OF MENTAL HEALTH AND DEVELOPMENTAL DISABILITIES
OFFICE OF CONSUMER AFFAIRS
CORDELL HULL BUILDING, THIRD FLOOR
425 5TH AVENUE NORTH
NASHVILLE, TENNESSEE 37243**

Employment Summary

The person named below is completing an application to be certified as a Peer Support Specialist with the Office of Consumer Affairs. In order to complete the application process, the direct supervisor must complete the following form regarding the applicant's employment, work responsibilities and supervisory plan. Once the form is completed, fax it to the Coordinator of Tennessee's Peer Support Specialist Certification Program at 615.253.3920. If you have questions, please contact the TDMHDD, Office of Consumer Affairs toll-free at 1.800.560.5767.

- 1) Prospective Certified Peer Support Specialist:

(Please Print Name)

- 2) Is the applicant named above employed to work in the role as a paid Peer Support Specialist?

Yes

☐

No

☐

- 3) **Title of Applicant's paid position within the agency**

Date of employment as a Peer Support Specialist _____

- 4) Number of hours assigned to work in this position per week: _____

- 5) A Certified Peer Support Specialist must be under the general supervision of a mental health professional in accordance with acceptable guidelines and standards of practice as defined by the State. A Mental Health Professional as defined by the State is a board-eligible or a board-certified psychiatrist or a person with at least a Master's degree and/or clinical training in an accepted mental health field which includes, but is not limited to, counseling, nursing, occupational therapy, psychology, social work, vocational rehabilitation, or activity therapy. Please provide the following information regarding the agency staff that provides direct supervision:

Name_____ Phone (____) _____ - _____

Job Title_____ Credentials_____

Agency_____ Email_____

Address_____

City_____ State_____ ZIP _____

- 6) Please describe the nature of the applicant's work responsibilities in the position and role as a paid Peer Support Specialist within the agency:

- 7) Please describe in detail the nature of your direct one-on-one clinical supervision interactions with this applicant:

- 8) Please describe in detail the professional development plan or goals for this individual within the agency:

My signature below affirms that all of the information contained in this document is true, and that I support this application.

Signature of Immediate Supervisor_____ Date_____